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A REVIEW OF USAID-SUPPORTED PARAMEDICAL TRAINING PROGRAMS FOR AFGHANS

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In response to the need for medical services in "resistance"-controlled areas inside Afghanistan, several Private Voluntary Organizations (PVOs) have established paramedical training programs for Afghans in the NWFP. Currently five such PVOs are receiving financial support from USAID

A review of these five PVO paramedical training programs was carried out from 25 January to 10 March 1986

The primary objective of four of the training programs is to train Afghans for managing combat-type wounds and injuries and managing common clinical problems for the Mujahideen. A secondary objective is training for the provision of medical services for the general population. The fifth training program is designed for upgrading the surgical skills and techniques for Afghan doctors and nurses.

As the general population also needs medical services, particularly children and women, it is suggested that the present paramedical training program be strengthened by adding a few priority topics to the course of instruction

Training for use of the skills and knowledge in the field setting is generally weak, and suggestions for improving this aspect of the training are discussed.

The PVOs carrying out paramedical training are as follows

Freedom Medicine - six-month training course The first course was started on 15 February 1986 for 16 trainees

German-Afghan Committee - nine-month training course The first course was started on 11 November 1985 for 15 trainees.

International Medical Corps - A four-month "Advanced" training course was started on 11 January for 27 trainees, and a Basic 12-month course was started on 3 February 1986 for 36 trainees

Medical Training for Afghans (MTA) - 18-month training course The first course was started in September 1985 and has 13 trainees

All of the above training programs, except MTA, plan to use the trainees for their operational programs inside Afghanistan. MTA plans to send their trainees back to their home area to set up clinics which will be supported by the Swedish Committee.

Surgical Training for Afghan Doctors and Nurses - This training program is designed to upgrade the surgical skills and techniques for formally trained Afghan doctors and nurses. A 20-bed surgical hospital is being set up for this purpose The training will be for 2-1/2 months for 10 trainees in each class This program is in the pre-implementation stage

Coordination between the five PVOs is minimal. Sharing of training materials was not observed, nor were trainers observed teaching or sharing their expertise outside their own group.

A comprehensive medical assistance plan should be developed to address separately immediate, intermediate and long-term objectives for all population groups. For this, a model planning matrix listing health risk factors was developed.

The initial work for this consult was difficult, as the PVOs were concerned that their programs might not be in agreement with USAID objectives. However, full cooperation was received, and this report presents the findings.

Suggestions and/or Recommendations

1 Training Content

a. Expand training content to include:

- i. managing selected pediatric and maternal problems
- ii. improving existing drinking water supply systems
- iii. community health

2 Training Design and Educational Methodologies

a. Improve training design and educational methodologies through

- i. mixing modules or subject throughout the course
- ii. conducting simulated training exercises and role plays
- iii. integrating anatomy and physiology into topics presented
- iv. preparing trainee for competently carrying out a carefully selected range of tasks

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- v adapting "western-style" treatment/recommendations in a manner that will not conflict with local beliefs and practices
- vi developing a mechanism for systematic feedback of information regarding the performance of the medical technician and relevance of training

3. Planning and Managing Paramedical Training

- a Prepare an operational plan to include detailed operational procedures
 - b. Develop a standard basic course for all medical technicians
 - c Appoint a full-time and long-term training director
 - d Establish a PVO cooperative supply unit
- 4 Conduct a training of trainers workshop
 - 5 Prepare a detailed medical assistance plan focusing on immediate, intermediate and long-term objectives
 - 6. Examine the relative health risk factors for all population groups and
 - 7. Prepare a health planning matrix with health risks defined according to an objective priority, i.e. immediate, intermediate and long-term

TABLE OF CONTENTS

	Page
I Background	4
II The Training Programs	6
A. Introduction	6
B Training Content	8
1. Introduction.....	8
2 Pediatric Priorities	9
3 Maternal Problems	10
4. Environmental Sanitation	11
5 Community Health	12
6. Summary	13
C The Training Design and Educational Methodologies	14
D Planning and Managing Paramedical Training Programs	17
1. Operational Planning.....	17
2. Standardization for a Basic Paramedical Training Course.	19
3 The Training Staff.	20
4. Drugs and Supplies.	21
III Description and Current Status of the Training Programs	22
A. Freedom Medicine	22
B. German-Afghan Committee	25
C International Medical Corps.	28
D. Medical Training for Afghans.	32
E. Surgical Training for Afghan Doctors and Nurses	35
IV Status of Coordination Between Training Programs	37
V Planning for Medical Assistance.	39

Appendix

F

APPENDIX

	Page
I Terms of Reference.....	47
II Private Voluntary Organizations receiving USAID Support for Training Afghan Paramedics.	50
III Principal Contacts.	51
IV. Development of a Model Course Outline for Freedom Medicine.. . .	52
V Planning for Medical Assistance Matrix	55

I. Background

Information regarding "resistance"-controlled areas in Afghanistan indicate that modern or scientific medical care is generally not available. The lack of health care services is a particularly acute problem for the Mujahideen, as this group probably experiences the highest rate of combat injuries and fatalities. Many fatalities, as well as secondary complications, could be avoided if immediate and proper medical aid was available. Further, the ability of the Mujahideen to maintain a state of combat readiness will be adversely affected if this group is unable to obtain diagnostic and treatment services for many of the common clinical problems.

Many war-related victims, both Mujahideen and civilian, somehow manage to reach Peshawar for medical/surgical care. A medical officer at one of the refugee hospitals reported that because of inadequate or incorrect first aid, victims frequently develop complications which require long-term care or amputations or suffer with permanent disabilities which, in certain instances, could have been avoided if proper medical aid had been provided. Victims beyond the reach of Peshawar and those unable to be transported long distances are unfortunately left without medical care.

Obviously the need for medical/surgical care for the Mujahideen and civilian populations within the "resistance"-controlled areas of Afghanistan is urgent. In response to this need, several private voluntary organizations have established medical assistance programs inside Afghanistan, and some have established paramedical training programs in the NWFP. The training programs are for Afghans who agree to return to Afghanistan to provide medical services within

"resistance"-controlled areas. Currently five such private voluntary organizations (PVOs) are receiving financial support from USAID.

According to the scope of work (see Appendix I), I have been requested⁴ to work with five designated PVOs (see Appendix II) to familiarize myself with their training programs to provide a current status report regarding the paramedical training, assist the PVOs with further development of training plans as appropriate, identify training topics that might be included to further strengthen the capabilities of the trainees to serve both Mujahideen and civilian medical needs, present observations and impressions regarding the training programs in general, including the existing status of coordination among the PVOs, and, provide suggestions which may be helpful for further strengthening the overall medical assistance plan.

Four of the training programs (Freedom Medicine, German-Afghan Committee, International Medical Corps and Medical Training for Afghans) are conducting training to prepare medical technicians for managing combat-type wounds and injuries (immediate first aid and follow-up medical/surgical care at a stationary or mobile health unit) and managing (diagnosing and treating) common clinical problems. Essentially, the focus of the training is on (although not limited to) providing medical/surgical services for Mujahideen and adult males. These courses, however, include some training on preventive or community medicine and pediatrics. The fifth training program (Surgical Training for Afghan Doctors and Nurses) is now in the ^{pre implementation} ~~preparatory~~ stage. The objective of this training program will be focused on upgrading surgical skills and techniques of Afghan doctors and nurses who are currently working inside Afghanistan.

Documents and other information regarding background, nature, scope or future plans for the USAID cross border (Afghanistan) medical assistance program were not available during this consult. The names and a short briefing about the five private voluntary organizations receiving some level of support from USAID for training Afghans were provided.

The advantage for having limited information was that opinions and comments were not influenced by previous reports. However, the disadvantage was that some of the comments/suggestions may have already been presented.

The guidance and support provided by Mr. Al Nehoda, Office of the USAID Representative in Peshawar, was very much appreciated.

II. The Training Programs

A. Introduction

In addition to the primary objective, i.e. medical/surgical services for the Mujahideen, a secondary objective is to provide similar services for the general population within the limitations (skills and knowledge level) imposed by the primary objective. To develop the capabilities of the medical technician to meet some of the priority needs for the secondary objective, training includes limited skill development for managing pediatric problems insofar as these problems relate to or are similar for managing adult male common clinical problems. (For instance, selection of medication and dosages is different for children.) Treatment for non-sex-specific common clinical problems of adult females would be essentially the same as for males, except that certain medications should not be prescribed during pregnancy and lactation. Surgical services

(managing combat-type wounds and injuries) are usually not age or sex specific. Therefore, the medical technician should be able to apply, as required, the same surgical skills and techniques for any population group.

Some elements of preventive health services, e.g. water, sanitation, control of communicable diseases and immunization, are included at a minimal level. As a course syllabus was not made available except for the IMC and German-Afghan Committee training programs, I am constrained to present only my impressions.

A comparison of the training programs was not appropriate, as some have recently started their activities while others are more advanced plus have the benefit of operational experience inside Afghanistan. The levels of financial resources are different, as well as the manpower pool of qualified or experienced trainers presently attached to the training centers or on call. Although the primary objective is the same, the skill level to which the trainee will be prepared is not uniform, since training durations range from 6-18 months. Also, there are variations in training approaches and educational methodologies. The ultimate test or evaluation will be the performance of the graduate. Will he be able to do the specified job competently and efficiently?

Comments regarding the training in general, however, are presented. The comments are focused on selected topics which, if addressed, should assist training managers with strengthening certain aspects of their training program. As the comments are not program specific, they may or may not apply to a particular training program. For discussion purposes, the comments are presented in three categories: 1. Training Content, 2. Training Design and Educational Methodologies, and 3. Planning and

Managing Training Programs, followed by a general description of each training program.

B. Training Content

1 Introduction

Keeping in view the primary objective and the urgency for trained medical technicians, the focus of the training - serving the medical needs of the Mujahideen - is appropriate, and the training content supports that objective. However, the population will expect medical services, and it is difficult to imagine that a medical technician will be occupied with providing emergency services to the extent that he will not have time for other duties. It was mentioned by one trainer experienced in Afghanistan that a major portion of "clinic work" involves providing medical service for the general population. However, training for medical services for the general population is very limited, but it should be possible to strengthen this aspect without compromising the primary objective. It is not suggested that the time periods for any of the training programs be extended, as that would be counterproductive. Trainers should be able to include additional subjects by reducing teaching hours allocated, e.g. theory or general medical knowledge, without adversely affecting the desired skill and knowledge level.

The most striking observation was the limited training for managing pediatric and maternal problems, as even during normal periods these two groups experience the highest morbidity and mortality rates. It is well understood that males will not ordinarily be allowed to treat women, at least not directly. On the other hand, it was reported, again by a

trainer experienced in Afghanistan, that women do in fact come forward for diagnosis and treatment for non-gynecological problems. The importance of mother and child health care is discussed in detail elsewhere in this report.

Specifically for the present training programs, it is suggested that thorough training be given for managing a few high priority maternal and child health problems.

2. Pediatric Priorities

For children under five years of age, the important child survival intervention techniques have been well-defined, i.e. the UNICEF GOBI (Growth Monitoring, Oral Rehydration Therapy, Breastfeeding, Immunizations) elements. In a study conducted in the Pushtoon area of Baluchistan, it was found that the two leading symptoms at time of death of children were related to diarrhea/dehydration and malnutrition. Combined, these two conditions accounted for 75% of the deaths. World-wide studies are available which have similar findings, and summaries of such reports may be seen in the annual UNICEF State of the World's Children report.

The technique for preventing death due to diarrheal dehydration is simple and effective. A home-prepared oral rehydration solution (ORS) consisting of a measured quantity of sugar and salt mixed in a liter of the cleanest available drinking water is all that is required, provided a quantity equal to the amount lost through diarrhea is given to the infant or child. The problem, though, is finding a way for this knowledge to be passed to the mother and will be discussed later. ORS has other practical applications, such as fluid replacement for serious burns.

Nutritional problems in a food deficit area are obviously difficult to address. Again referring to a Pushtoon community in Baluchistan which has many similar characteristics with tribal areas in Afghanistan, the majority of the malnourished children were not from the lower socioeconomic households, suggesting a major factor is lack of knowledge regarding introduction of supplemental foods at four or six months of age along with breast-feeding and weaning practices. Vitamin supplements cannot replace food but certainly are needed for treatment of vitamin deficiencies.

Another problem is parasitic infestations. These infestations not only have a negative impact on the health of the child but also seriously exacerbate any nutritional problem that may exist, particularly hookworms.

Fevers and pneumonias in children are common and often very serious or fatal, as are secondary infections due to measles and other common childhood diseases.

Immunizations can prevent many deaths. Therefore, knowledge regarding immunizations is important even though such services cannot be introduced until a cold chain is organized.

3. Maternal Problems

As previously mentioned, it will be difficult for a male medical technician to deal with maternal problems, if at all. However, neonatal tetanus is an easily preventable disease and apparently a leading problem. Prevention is through clean delivery techniques, plus ensuring the cutting instrument and material used for tying the cord is sterile, and/or giving tetanus toxoid injections (two at one-month intervals).

during the last trimester. In the absence of refrigeration for storage of tetanus toxoid and lack of access to pregnant mothers or the dai, probably the medical technician can have little impact except in his own family, where he can at least promote delivery in a clean environment and ensure the instruments/materials are sterile. The problem is serious enough, though, for at least teaching the basics and exploring ways in which the knowledge can be transferred to the local dai.

Anemias are common in pregnant and lactating mothers. Treatment with iron and folic acid tablets can help reduce this problem.

4. Environmental Sanitation

Environmental sanitation programs have proven to be difficult to implement, even with a fairly sophisticated infrastructure in place. In Baluchistan, for example, considerable effort was extended on a household latrine program for which, even after more than three years, little progress could be demonstrated due to cultural as well as operational constraints. Therefore, at this time it would not be feasible to try to develop this aspect (latrines) of an environmental sanitation program.

One potentially beneficial and relatively easy activity would be a program, using a low level of technology, to improve the existing drinking water sources. Open wells, for example, could be protected from the return flow of surface water by sealing three or four feet of inside lining, constructing a watertight platform around the well, installing a fixed bucket pulley system and covering the top of the well. For this the medical technician could carry out a simple survey to identify the existing water sources, organize an improvement program and finally, encourage people to draw their drinking water from the safest source(s).

5 Community Health

The effectiveness of a health unit or clinic can be significantly enhanced if the delivery of services include a community health program. There are a number of reasons for this statement. First, good community relations promote a two-way flow of communications between the clinic and population served and make it possible for the medical technician to address health problems that he could not accomplish without assistance from the local residents. The medical technician needs people willing to be trained to work for reducing diarrhea/dehydration and malnutrition problems among the under-five-years-of-age group, for carrying out an iron/folic acid tablet distribution program and for implementing a drinking water supply improvement project. For these and other activities the medical technician needs to establish a good working relationship with village influentials and heads of households. This requires special skills in communications, interpersonal relationships, teaching and home visiting. These skills usually have to be developed through training and field practice. In a clinic setting, people come for advice and treatment, whereas for a community program the medical technician must go out to the people. Many of those who are just starting their career find it difficult to leave the secure surroundings of their clinic to meet people for initiating a community activity. Training and knowledge about what to do and how to do it is needed.

The medical technician needs to know the community from a health perspective, e.g. health needs, problems, most nutritious locally available foods, traditional practitioners like a bonesetter who can be involved, the support of the mullah and people willing to assist when

necessary. A local resident may know much of the above, but a conscious awareness regarding these aspects needs to be developed to a working level, along with skills and knowledge for practical application.

Particularly in the present situation, the medical technician should know the geography of the service area, e.g. travel times between villages, alternate routes, safe havens and contacts in the surrounding village, to assist with transporting injured. Also, the medical technician should have a cadre of trained first aiders spread throughout the service area, as he cannot always be present in the event of an attack. In fact, it might be more efficient for the medical technician to remain at a designated point to receive casualties and coordinate his activities with the local commander(s).

The exact design of a community health program will, of course, depend upon the operational plan. The above discussion was presented to illustrate the range of possible community activities, as it is up to the planners to decide what will or will not best serve the objectives of their program.

6. Summary

In summary, it is suggested that only a few topics which have the potential for reducing some of the priority health risks among the general population be added to the training, if presently not included. The priorities are

Pediatric Priorities

- a) Managing diarrhea/dehydration
- b) Nutrition education/advice and treatment
- c) Managing common clinical problems
 - i Parasitic infestations
 - ii. Childhood communicable diseases/secondary complications, immunization information
 - iii High fevers and pneumonia

Maternal Problems

- a) Neonatal tetanus (prevention)
- b) Anemias

Environmental Sanitation

- a) Improving existing drinking water supply systems

Community Health

- a) Working with people
- b) Organizing community activities
- c) Teaching extension workers
- d) Medical intelligence and surveillance

C The Training Design and Educational Methodologies

Paramedical training programs generally have two equally important training objectives. One is developing task or duty-specific skills and knowledge, while the other is developing the trainees' ability to use

these skills in an integrated manner. Integrated manner refers to the medical technician's ability to plan and organize his work according to the priorities and cope with or direct a variety of activities simultaneously. This is particularly important for triage and emergency situations

The manner in which the course is designed, as well as the teaching techniques, can significantly influence the level to which the medical technician is able to deliver integrated services. A few suggestions which may help to achieve this are as follows

1. If possible, mix the modules or subjects covered rather than completing one module in a continuous block of time, for example, diseases of the respiratory system and managing thoracic wounds. The concept is to develop the trainee's ability to move quickly from one activity to another. The extent to which switching between modules can be done will, of course, depend on the trainee's general ability.

2. Simulated training exercises and role plays are useful for helping the trainee with organizing his work according to priority needs. For example, in a simulated clinical setting there are three patients with different problems, all of whom are demanding immediate attention: a minor scalp wound, a father holding a severely dehydrated infant, and an adult male complaining of a red and painful eye. The trainee will then demonstrate how he would manage these three cases. Will the trainee treat the wound first, or will he address the emergency, i.e. the severely dehydrated infant?

Various types of simulated exercises can be planned, e g setting up a clinic or mobile unit with village-type resources. The extent to which such an exercise is carried out will depend upon the number of props the trainer wishes to provide. It could simply be a layout of the clinic area or actually setting up a field clinic

3 For training programs of shorter duration, it would be useful to integrate anatomy and physiology into the topics presented rather than covering the subject separately. Programs of longer duration may wish to consider this for reducing the length of the course. Practical ability should be the prime consideration for training programs responding to an urgent need

4. There is just so much a trainee will be able to assimilate into a working level. Trainers should avoid including more than the trainee will be able to cope with. It would be much better to reduce the number of tasks and ensure that the trainee will be able to carry them out competently, rather than a larger number of tasks less competently.

5 Discussions which lead trainees to think about traditional health beliefs and practices are important, as this will help the medical technician to adapt "western style" treatment/recommendations in a manner that will not conflict with local beliefs and practices. Some practices can be beneficial or totally harmless, while others may be harmful and should be discouraged. The importance of working within the cultural framework cannot be overemphasized. Trainees often are so enthusiastic about adopting "western style" medical practices that the importance and influence of traditional beliefs is overlooked

6. Since these are new training programs and for the most part developed outside Afghanistan, a mechanism is needed for systematic feedback of information regarding the performance of the medical technician and the relevance of the training for his working environment

D Planning and Managing Paramedical Training Programs

Although training content, design and educational methodologies are interrelated and part of planning and managing paramedical training programs, issues or factors which have wider implications for the training as a whole were separated out for presentation in this section.

1. Operational Planning

The following discussion which emphasizes the importance of operational planning should not be interpreted as implying that the paramedical training programs have not given this aspect consideration. Rather, the greater the input into an operational plan the greater the probability of achieving the desired objectives. While some of the training programs have a general operation plan (German-Afghan Committee and International Medical Corps), others are just beginning to address the operational aspects and have only some notions about how the graduates will function in the field.

The success of any paramedical training program ultimately depends upon the ability of the graduate to apply in an efficient, coordinated and integrated manner the skills and knowledge acquired in his working environment or for the job he is expected to carry out. Therefore, it is important to ensure that training includes sufficient time not only for

skills and knowledge development, but for the practical application of these skills in the field.

Past experience, however, has shown that trainers sometimes underestimate the need and importance of practical training. Practical training does not mean how to manage a wound, apply a cast or diagnose and prescribe a medication, rather, it means the field operational procedures.

Field operations depend upon the job the paramedic is expected to carry out and, in general, refers to the delivery methodology or procedures. This includes organizing and setting up a clinic, managing the clinic's patient flow, providing for clean and dirty areas, maintaining supplies, advising the commander regarding medical needs and priorities, acquiring a thorough knowledge of the area and population to be served.

Theoretically, the preparation of a fairly detailed operational plan should be one of the first steps for designing a paramedical training program. However, the situation is not normal, and medical assistance is needed on an emergency basis. Nevertheless, it is important for training managers to allocate sufficient time for completing this exercise. Even with the existing constraints, it would be possible to evolve a tentative plan. Also, the specific tasks the paramedic will be expected to carry out can be identified (task analysis), which will help the trainer with course design and content. At the end of the training period, the paramedic will know what to do, when, where and how.

Further, it would be beneficial for the commander of the area to know, if not exactly, what can be expected of a medical technician, e g the tasks, skill level and limitations, preventive health services, training first aid extension workers, setting up field aid stations, reporting on medical problems such as the possibility of an epidemic, and supply levels for managing combat-type injuries.

2. Standardization for a Basic Paramedical Training Course

Among the PVOs' training programs there are variations in course design, content, educational methodologies and length of training. These variations reflect the organization's particular training objective and the level to which the trainee is to be prepared. Fundamentally there is nothing wrong with this, as the trainees are being prepared for a specific role. However, it may prove to be a disadvantage if, for example, the graduate moves to another area to work for a different organization or commander. Expectations for the individual may exceed his qualifications. If the commanders or other organizations are aware of what a paramedical graduate should basically be able to do, it will be helpful for avoiding confusion and misunderstandings and make it possible for his supervisor to assign appropriate tasks and utilize his skills to the fullest extent. In longer terms, the graduate may wish to join the health service when peace is restored, and it will be difficult for administrators to know where such individuals can best fit into the delivery system.

As there would be immediate as well as long-term benefits, it is recommended that the PVOs adopt a basic standard course and certify that a

set of defined tasks are included and a minimum skill and knowledge level is achieved. Beyond the minimum, each program could have its own certification.

3. The Training Staff

All the PVOs are using short-term expatriate trainers as well as Afghan staff who have either a medical background or function as interpreters in their training programs. Some programs rely more on expatriates for trainers than others. This is no doubt a good strategy, as it enables the PVO to select and recruit volunteers according to the skills required for various components of the training. Most expatriate trainers are present for a short duration, i.e. a few months but less than one year. As mentioned, this strategy has certain advantages, but planners should also be aware of some of the disadvantages.

The main disadvantage will be maintaining continuity and quality within the training program. No doubt the volunteer trainers will be expert in their field, but they may not have training skills or past training experience. Further, with frequent changes of trainers, the particular educational need of individual trainees will not be known in sufficient depth to maintain the same level of tutoring that each individual trainee may require.

To maintain the continuity as well as quality of instruction, it is essential for each training program to provide for a full-time training director. This function cannot be covered on a part-time basis or by staff who have general administrative/management responsibilities, as their time and attention will be frequently diverted to other priority activities.

The International Medical Corps has taken this factor into consideration, as evidenced by the appointment of a full-time and fully qualified Afghan training director. It may, of course, not be possible for other PVO training programs to recruit an Afghan training director who has the appropriate skills and orientation. However, this point is of sufficient importance for donor as well as PVO managers to consider a possible solution

One possibility is to recruit a volunteer trainer for a longer duration, say one year. This will mean assuming additional financial obligations, as it will not be very realistic to expect to find a qualified trainer willing to volunteer his/her services for one year. Unfortunately, the financial documents are not available for review, but if training staff costs were compared with the total cost, the percentage increase needed for funding a full-time training director might be negligible, whereas the payoff in terms of quality output could be significant.

4 Drugs and Supplies

The Swedish Committee has been involved with purchasing drugs and medical supplies for the past few years to support various programs inside Afghanistan. During this period the Committee has developed a generic drug list to avoid confusion associated with purchasing and, more importantly, prescribing brand name drugs. In addition, the Committee has evolved standard supply kits for serving different program requirements and needs. Some of the PVOs have indicated they are using or intend to use the same generic drugs and supplies for their training and operational programs. This is definitely a positive factor for quality care.

According to the Director, Swedish Committee, some of the PVOs will be purchasing their drugs and supplies through the Committee. It was pointed out, though, that the Committee will only be able to set aside for the PVOs only 1/5 of the total quantity kept in stock. Beyond that level, the PVOs will have to arrange for their own drugs and supplies.

As considerable staff time and effort is required for purchasing drugs and medical supplies, it would be worthwhile for the PVOs to consider pooling their resources and setting up a supply unit.

III Description and Current Status of the Training Programs

A. FREEDOM MEDICINE

This Private American Voluntary Organization has recently established a paramedical training program for Afghans in the NWFP. The administrative headquarters is located in Peshawar (4 A Railway Road, University Town Telephone 41457), while the training center is located near Thal (about a 2-1/2 hour drive from Peshawar). The home office is in Honolulu (941 River Street, Suite 201, Honolulu, Hawaii Telephone (808) 521-2241.) The Home Office Administrator is William H. Dendle III. For local operations, the Field Director is Gaye LeClere Brenner, and Robert Brenner is the Project Director.

The primary objective for this project is to support Afghan resistance commanders by training Afghans for providing medical/surgical services for the Mujahideen.

The selection criteria for the trainees is as follows

- 1 Recommendation of a local commander
2. Verification of the Commander's recommendation through the political parties in Peshawar
- 3 Written and oral examinations
- 4 Expressed willingness to return to Afghanistan to provide medical support for the referring Commander
- 5 Trainee placement along the evacuation route

A total of 16 trainees were selected for the first course which started on 15 February 1986. The training course is scheduled to run for six months. New courses will be started every other month at appropriate intervals.

The training staff are American volunteers who have appropriate backgrounds for teaching basic medical/surgical skills, particularly for combat-type injuries. The American Volunteers are Susanne Brown, M D , MPH, Joel Warren, Medical Laboratory Specialist, and James Wengenroth, Special Forces Corpsman and Advanced Emergency Services Paramedic.

As the trainers arrived during my assignment period, I was requested by Freedom Medicine to work with them on development of course materials. This activity is described elsewhere in the report.

As mentioned previously, the course is for six months, focusing primarily on battlefield medicine. For training materials, the Army Medical Corpsman (Basic and Advanced) Training Manuals will be used as well as other references such as "Where There Is No Doctor" and "Helping Health Workers Learn ". With regard to the Army training materials, it will prove to be an excellent reference, but adaptations/modifications

will be needed to compensate for the different backgrounds, abilities and education levels of the trainees. The Army courses were designed for corpsmen to work within a highly organized, disciplined and regulated system, including adequate levels of supervision.

The training approach stresses skill development and minimizes theory, which will be integrated along with skill development. For clinical practice, the Organization plans to establish a hospital and outpatient clinic. However, in the meanwhile, the surrounding refugee camps have operational clinics which could be used for clinical practice. Further, these camps could be a useful training ground for community health activities. Plans are being prepared for organizing simulated field exercises, a very useful training technique.

The location of the training center is very appropriate, as the Center closely resembles the facilities and environmental factors that may be found inside Afghanistan.

The Center has a large compound that includes a typical local-type building with a series of separate rooms. For approximately the past three months, an American Volunteer has been directing a program to improve and expand the facilities, e.g. building latrines and bathrooms, improving and protecting the existing drinking water source, building a field kitchen, and installing a generator and electric connections. A very excellent job.

Tents are used for accommodating both trainees and staff. A classroom has been prepared using temporary materials, and seating is in the traditional fashion - sitting on the floor. Excellent! Chairs and tables are not used in rural Afghanistan. For the Afghans, just living in an

environment that has been modified using local materials to meet basic sanitation and other requirements should be a valuable learning experience. These trainees may at some future date be called upon to organize a camp or clinic complex, and hopefully they will remember from their experience the basic requirements for establishing a safe and healthy environment

My overall impression is that the course is on the right track, although I feel it would be strengthened by adding the health activities described elsewhere, if already not planned for inclusion, i.e. a few pediatric priorities, maternal problems, improving existing drinking water supply systems and community health.

It is my impression that operational plans for establishing, running and backstopping field stations or clinics are yet to be developed. This should be a priority, as for the trainees to be effective, they must be trained to function according to the operational procedures.

Putting together such an ambitious training program in such a short period of time is remarkable and very amply demonstrates the management and administrative skills of the organizers

B. GERMAN-AFGHAN COMMITTEE

This Private Voluntary Organization's paramedical training program was established to support and expand the clinics run by the Organization inside Afghanistan as well as to support the resistance movement. The administrative office is located on Nasir Bagh Road (GPO Box 540), Peshawar. Telephone 74484. The training center is in Sadda, about a

3-1/2 hour drive from Peshawar on the Kohat-Parachinar Road Dr Frank Paulin is the Medical Advisor, Mr M E Rashid is the Director, and Mr Rolf Lerch is the Representative of the German-Afghan Committee Information regarding this training program is limited, as Dr Paulin was not present for most of my assignment Because of travel restrictions, I was unable to organize a field trip to the training center

The goal of the program is to provide medical services for the Mujahideen and general population Although the introduction to the course syllabus stresses services for the Mujahideen, it was explained that the Mujahideen would be served as needed along with the general population. The concern of the organization is focused on the needs of the people and not on any one particular group

Development activities for this program were initiated in January 1985, and actual work on establishing the infrastructure, i e headquarters and training center, began March/April 1985 The present and first training program was started on 11 November 1985 for 15 trainees

The training program was originally planned to run for nine months - divided into three, three-month phases Phase I, theory - extended for two months to cover epidemiology, Phase II, practical work at one of the program's clinics inside Afghanistan, and Phase III, critique of practical experience and additional training as required

The first phase has been completed However, travel to the clinics in Afghanistan is delayed due to winter climatic conditions until April During this one-month period the trainees will be working on community health activities in nearby refugee camps

For technical training, four Afghan doctors are assigned, two of whom are always present at the training center

The training center has three classrooms, one laboratory, office, store, kitchen and accommodations for trainees and staff

The reason for establishing the training center in Sadda, it was explained, was because of the overcrowded conditions in Peshawar and the potential attraction for the trainees to remain in Peshawar rather than returning for work in Afghanistan. This is certainly a valid justification. However, the added benefit is that training will be conducted in a learning situation similar to the working environment inside Afghanistan. Also, there is the potential for structuring more realistic simulated training exercises in the nearby area.

The rationale for mainly an Afghan training staff is 1) commitment toward working for improved conditions in their own country will be at a much higher level than expatriates, 2) knowledge of cultural and social aspects, including the educational process, and 3) upgrading the skills of Afghans, which promotes the overall philosophy of the Organization. The German-Afghan Committee is supporting six clinics (five now, as one was recently destroyed) and three extension centers spread through seven provinces. Plans are under preparation to expand the operational coverage by establishing several more clinics in the immediate future.

The clinics are staffed by a doctor and nurse, along with support staff. Supplemental staff may be assigned from time to time.

According to my understanding, the clinics are fully supported by the Committee, i.e. drugs, supplies, staff salaries, etc. Requests for supplies are sent directly to the Committee, which has its own logistical support system.

A syllabus outlining the subjects and topics covered for Phase I, including hours of instruction and daily schedule, is available.

Mr. Rashid, Director, suggested that a Training of Trainers' Workshop would be helpful for the Committee's training staff and would probably be helpful for trainers from other PVOs working on cross border assistance training programs. This is an excellent suggestion, particularly at this juncture, as all PVOs are now in the process of training the first group. Such a Workshop could provide a forum and mechanism for discussing training ideas, designs, content approaches and methodologies in an open and objective manner in addition to development of training skills and techniques. The need for such a Workshop is immediate, and the potential for strengthening the present training programs cannot be overstated. It is recommended that this suggestion be given priority consideration.

C. INTERNATIONAL MEDICAL CORPS

This is an American Private Voluntary Organization involved with paramedical training for Afghans. Initially the Organization's work was focused on providing cross border medical assistance in "resistance"-controlled areas of Afghanistan. Because of the shortage of trained health manpower and the need for expanding health care delivery services, a paramedical training program was established in Peshawar.

The training center is located in Nasir Bagh on Nasir Bagh Road, Peshawar Telephone 41755 Dr Roashan is the Training Director The administrative office is located off old Bara Road (Afzalabad) near University Town Police Station Telephone 41156 Leonard Leshuk is the Field Operations Administrator Dr Robert Simon is the Principal Training Officer based in Los Angeles, California Dr Simon is frequently in Peshawar to guide and promote the work of the Organization The address of the home office is P O Box 49525, Los Angeles, CA 90040 Telephone (213) 427-0031

The primary objective of the training program is to train Afghans for providing medical/surgical support for local Afghan resistance commanders and the Mujahideen inside Afghanistan. The focus of the training is on managing combat-type wounds/injuries and managing common clinical problems of adult males. A secondary training objective is medical/surgical services for the local population in general

The first training program was started on 11 January 1986 for 27 Afghans who have had prior medical experience This "Advanced" Course is scheduled to be completed around 20 April 1986 A basic 12-month paramedical training course was started on 3 February 1986 and has 36 trainees enrolled Dr Simon stated that the skill/knowledge level for both groups (Advanced and Basic) at the end of the instructional period would be essentially the same

The training emphasizes practical application of skills through simulated training, e g practice suturing, using animals for developing surgical skills and techniques, medical laboratory training, all in a setting similar to that which may be found in Afghanistan In addition, a

clinic for serving Afghans from nearby refugee camps will be run by the training center to provide the trainees with supervised outpatient experience. It was stated that about midway through the course (1 June) the trainees will be sent back to Afghanistan for four months of supervised field training. The operation plan proposes establishing 20 "clinics" spread throughout the country. According to my understanding, the trainees will assist with establishing the new clinics as part of their field practice.

Backstopping, i.e. drugs, supplies, equipment, etc. will be provided by IMC.

The types of clinics have been divided into four categories, i.e. Type A, Type B, Type C and Type D. Type A Clinic will be staffed by an Afghan doctor and medical technicians who will be managing more complex cases. This facility will have an inpatient capability. Type B Clinic will be staffed by a medical technician who is capable of independent duty. Type C Clinic will be temporary and serve the medical needs of the community and Mujahideen field operations. Type D will be mobile, i.e. the clinic can be packed and moved within one or two hours. Staffing will depend on the particular objective.

The training, as previously mentioned, emphasizes practical application of skills. In addition, the subjects taught are mixed as appropriate, e.g. wound care, surgical techniques and common clinical problems - a very good approach for not only integration of theory and related skill development, but the promotion of the ability of these trainees to use their skills/knowledge in an integrated manner. In other words, it reduces the tendency for compartmentalizing and promotes

preparing a multipurpose worker who will be able to cope simultaneously with a variety of problems

The training center is located in a large well developed compound which has a large building with adequate classroom space as well as space for setting up simulated training sessions. Residential accommodations for the trainees (two recently constructed buildings) is adjacent, as well as a nearly completed clinic. The expatriate training staff are also accommodated within the compound.

The training staff is a mix of Afghans (doctors and support staff like a translator and American Volunteers) who remain for a short period of time - from a few weeks to six months, depending on the instructional requirements. The number of expatriate staff during my visits were considerably more than Afghan staff. It seems that IMC has a large pool of expert volunteers who may be recruited for specialized training as required.

As previously mentioned in this report, it is not appropriate to attempt to compare these five paramedical training programs, as some are just starting, while others, from a training perspective, are more advanced. However, there is no question that the IMC is at the more advanced state. The course materials have been developed (three modules covering Anatomy and Physiology, General Medicine, and Surgery) and translated into Dari, a medical laboratory is set up and functioning, training aids like models, charts, surgical instruments and microscopes are in place and in use. In general, all that is basically required for establishing a paramedical training program seems to be in place. This is not meant to imply that additional medical equipment and aids are not required.

My overall impression is that this is a well designed, organized and managed training program. My only reservation - based on a review of training materials, interviews and observations - is, will the trainees be able to understand, assimilate and competently apply the rather vast range of skill/knowledge planned for this 12-month training program? Perhaps the expectations are somewhat unrealistic. Obviously this question can only be answered after the trainees are functioning in the field. It might be worthwhile, though, to consider eliminating those topics which are low priority in terms of relative health risk and focus training on high risk factors. A trainee prepared to competently carry out a smaller set of tasks may be a greater asset than a trainee who has reduced skill levels for managing a larger set of tasks. The rationale for a larger set of tasks is that referral and transport to Peshawar or other distant locations is not practical. Therefore, the medical technician will need to have the capability for managing a greater variety as well as more complicated problems than normally expected. Certainly this rationale has its own merits.

D MEDICAL TRAINING FOR AFGHANS (MTA)

This organization was established in August 1985 through the cooperative efforts of Belgium and French non-profit organizations - Solidarite Afghanistan (Belgium), Aide Medicale Internationale (French) and APEFE (Belgium). The administrative headquarters and training center are located in Peshawar, 14 A Park Road, University Town. Telephone 41492. The Project Manager is Michel Tonneau.

The training program was established in response to the need for trained health manpower to support the Mujahideen and civilian population in "resistance"-controlled areas inside Afghanistan

The first course was started in September 1985 and scheduled to run for 18 months. There are currently 13 trainees enrolled in the program.

The training complex includes a 20-bed hospital (operational), classrooms and residential accommodations for both trainees and expatriate staff. A daily, except Friday, outpatient clinic is held from 0900 to 1200 hours.

The course has been divided into three six-month phases. Phase I concentrates on classroom presentations to cover basic subjects such as anatomy, physiology, etc. but also includes an introduction to skill development within the hospital and outpatient clinic. Phase II will focus more on skill development, but classroom work will be continued, and Phase III will focus on surgery (theory and practice) as well as the continued development of general medical skills. Morning sessions are usually for practical work within the hospital, and afternoon sessions are for classroom instruction.

The training staff usually has two expatriate doctors and two expatriate nurses who are assisted by Afghan translators. The trainer with whom I spoke in some depth was Dr. Henri Metzger.

Phase I of the training has just been completed. Two of the trainees' examination marks were sufficiently low to question whether they should be continued. However, the trainers are of the opinion that these two trainees were able to demonstrate a more-than-adequate skill level and will be allowed to move into the second phase of training.

As the Organization does not intend to implement programs inside Afghanistan, the graduates are expected to return to their home location to deliver health services. The Swedish Committee has agreed to support their activities inside Afghanistan with drugs, equipment and expendable supplies.

As the hospital is small, the main concern now is to expand the opportunities for skill development training. Contact with other treatment centers serving Afghans are being made to request that MTA trainees be allowed to work under supervision in their centers for both medical and surgical training.

In view of the urgent need for health care providers inside Afghanistan, it would be appropriate to explore ways in which the duration of the course could be shortened. This should be possible without compromising quality by carefully defining and limiting the training to the essential skills/knowledge required for managing the most common clinical problems and emergency surgical services. If the basic subjects were integrated into presentations addressing common clinical problems of the respiratory system, for example, a reduction in the total training hours could be achieved.

As the trainees are expected to establish a "clinic", the training could be strengthened if the trainers organized a series of simulated training exercises, e.g. setting up a clinic, transporting casualties, and triage. In addition, it would be useful to carry out orientation training for community health in one of the nearby refugee camps. This would enable the trainees to begin developing their communication skills and practice teaching. Such tasks such as nutrition and diarrhea/dehydration

problems among the under five age group and environmental sanitation could be covered

Trainees during the morning session rotate through the various hospital services. During one observation period the trainees were conducting the outpatient primary physical examination, and their diagnosis was then checked by the physician prior to prescribing treatment.

Overall, the program seems well organized and managed. The main need from a training perspective is to work on streamlining the course to reduce the total training period. Further, the trainees would be in a better position to organize health services in their area if a tentative operational plan for establishing and running a clinic, including outreach services, was developed and used for organizing simulated training exercises. The Organization's plan to widen the opportunities for skill development within the centers serving Afghan Refugees is very good and should be encouraged.

As I could not review the training materials in French, I can only suggest that the training should develop the capabilities of the trainee to manage a few of the high risk problems experienced by mothers and children, if not already included.

E. SURGICAL TRAINING FOR AFGHAN DOCTORS AND NURSES

This training program was initiated through the efforts of a French anaesthetist, Areille Calmejane. Ms. Calmejane, who has had experience with providing clinic-based services for the Mujahideen and about 1-1/2 years experience with the Swedish-Afghan Committee in Peshawar, recognized a need for upgrading the skills of Afghan doctors and nurses.

providing emergency surgical services for the war wounded in Afghanistan. In response to this need, a Private French Voluntary Organization (Cours de Recyclage Pour Medecins Afghans) was recently (December 1985) established in Peshawar. The main office and residence for the expatriate staff is located at 47-C-11 Sahibzada, Abdul Qayum Road, University Town. Telephone 40968.

The objective of the program has two interrelated aspects: 1) upgrading the surgical skills and techniques of Afghan doctors and nurses, and 2) providing surgical services for the war wounded.

For these interrelated objectives a 20-bed surgical hospital is in the process of being set up in Peshawar. The hospital/training facility is located just off the G T highway on the eastern side of Peshawar, almost exactly across the road from the city limit marker. Initially the building was a hotel. However, renovations and modifications for converting the structure into a hospital are nearly complete. It is anticipated that the facility will be ready in about three weeks. Given the difficulties for this kind of construction work, I think it is an excellent demonstration of Ms. Calmejane's administrative and management skills. This 20-bed hospital will have two surgical theaters and all the basic support facilities like x-ray, laboratory, kitchen, laundry and supply section. If required, the bed capacity can be increased. Only patients requiring surgical services will be admitted. Patients may be referred by other hospitals like ICRC or transported directly from the border. The Government of Pakistan has given its approval for this hospital.

Selection of trainees will be made in consultation with the political parties and organizations involved with cross border medical assistance. The basic requirements are that the doctors and nurses have completed a formal training course, have recent work experience inside Afghanistan and express a willingness to return to Afghanistan.

In addition to the anaesthetist, Arielle Calmejane, the training staff includes a surgeon, Dr Hario, a surgical nurse, Jacques Omayon, and a physiotherapist, Jeanne Robin. The surgical nurse and physiotherapist arrived about four weeks ago and the surgeon on 2 March. To support the training and delivery of surgical services, four Afghan staff nurses and one Afghan doctor with recent experience inside Afghanistan will be recruited.

The exact training will depend upon the skill level of the trainee. This will be determined through examinations and demonstration of skills. Therefore, the course will have to be tailored to meet the training needs for each group as well as each individual. It is anticipated that the duration of the course will be for 2-1/2 months for a maximum number of 10 trainees in each course.

The current status of this program is ^{very difficult} ~~prayerful~~.

IV Status of Coordination Between Training Programs

It is difficult to state with any degree of accuracy the exact status of coordination among the Private Voluntary Organizations involved with training Afghans for work within "resistance"-controlled areas of Afghanistan. When the question is asked directly, the response is positive. "Yes, there are regularly scheduled coordination meetings." However, beyond that, the answers become unclear and vague.

Based on comments while discussing other matters, my impression is that at a practical cooperative level, coordination is minimal. Staff do not seem to have much information regarding the other training programs, e.g. course content, operational plans, etc.

Some specific PVOs, though, seem to have a very close working relationship - Freedom Medicine and Medical Training for Afghans, for example. This is not to say that these organizations do not meet regularly with other PVOs. I mention this only because I have observed the relationship between Freedom Medicine and Medical Training for Afghans.

Instant Status of Coordination

At the functional level, evidence of coordination between the PVOs was not observed. For example, sharing of training materials, i.e. course outlines, lesson plans and training aids, was not seen. Nor were trainers observed teaching or sharing their particular expertise outside their own group. This observation was supported by the questions asked regarding training activities carried out by other PVOs. Most frequently asked questions were about the International Medical Corps training activities.

As vehicles are in short supply, sharing vehicles at this time would not be practical.

During a meeting on 3 March at the German-Afghan Committee, it was mentioned that all PVOs working inside Afghanistan or involved with cross border assistance have decided to establish a coordinating organization. It seems that this proposal is at a very early stage, as specifics were not known except that such an organization would be created and have its own staff.

V Planning for Medical Assistance

Planning and developing programs to train Afghans for medical assistance within "resistance"-controlled areas in Afghanistan would be greatly facilitated if a detailed medical assistance plan or analysis of the health needs and priorities was available. Such a plan could assist donor as well as private voluntary agencies with determining how their particular inputs might be directed to achieve maximum potential benefit, while keeping in view the priority health needs of the population. In other words, if a medical assistance plan is prepared, the needs and health priorities of all population groups, including the Mujahideen, could be considered. This would be beneficial for evolving an integrated and coordinated assistance strategy that could address not only the emergency requirements but the longer range implications and objectives. On the one hand, there is an urgent need for providing medical care and services for the Mujahideen. (This need will be partially met by Afghans currently enrolled in the paramedical training programs.) However, on the other hand, what are the long-term implications for this type of assistance? For example, will the graduates of such training programs be recognized as qualified health care providers and incorporated into the health care system, or will they find no other option but to establish their own private practice? Also, what will happen to the clinics or hospitals when outside funding is reduced or not available?

The above questions may seem premature at this juncture. Nevertheless, some thoughts on the topic are indicated, as the question will eventually be asked and have to be answered.

Actually, the concerns are considerably more basic and fundamental. These concerns are 1) As there is an urgent need for medical support for the Mujahideen, are these training programs actually able to meet this need on an emergency basis? (Obviously services can be provided only in selected locations) and, 2) What about health services for other population groups at high risk, such as children and mothers?

Although these concerns are interrelated, they will be discussed separately, followed by a description of how they may be integrated into a comprehensive medical assistance plan.

Providing Health Care Services on an Emergency Basis

The present paramedical training courses are designed to run for six months (Freedom Medicine), 10 months (German-Afghan Committee), 12 months (International Medical Corps) and 18 months (Medical Training for Afghans). At the very earliest, the first group of trainees will not be available until September 1986, with most not available until sometime in 1987. The exact times are not important, since it is clear that this training strategy cannot meet the expressed need, i.e. immediate fielding of trained health manpower.

Therefore, an alternative strategy should be identified. For evolving a strategy, it would be useful to consider formulating a medical assistance plan that is designed to address separately the immediate, intermediate and long-term needs or objectives. It will be somewhat difficult to fit the needs into arbitrary categories because of the interrelationships. However, each category presents special problems which require different inputs and considerations.

As medical services are essentially not available in "resistance"-controlled areas and combat activities are expected to intensify during the spring and summer months, the following time periods should be reasonable for consideration of specific objectives

<u>Objective Category</u>	<u>Time Period</u>
1 Immediate	0 to 9 months
2 Intermediate	10 to 24 months
3 Long-term	25 months +

The time periods are assigned primarily to illustrate the relative urgency for each category. Even if a specified activity cannot be met within the objective category time period, listing out the priority activity should assist planners in maintaining a perspective on what should be done as well as maintaining a systematic approach for their medical assistance efforts. Also, it might help planners with deciding whether their agency can realistically accomplish a particular objective or respond to a specific request. Specifically, the present paramedic training programs, according to the above definition, fall within the intermediate time frame. As the immediate objective of emergency medical assistance for the Mujahideen remains, planners should consider alternative strategies or approaches for supporting the immediate objective. The following strategies are presented as an example

Alternative I

Presently there are a number of trained Afghan health care providers working with various Afghan Refugee programs. Perhaps a number, say equal to the expected output from the four training programs during the next 12 to 18 months, could be recruited to return to Afghanistan for a time-limited period. The time limit would be until these workers are replaced (may not be the same location) by the graduates from the four training programs. This plan, of course, would be disruptive for the ongoing refugee health programs. However, newspaper reports indicate there are from five to eight thousand unemployed doctors in Pakistan. With some financial incentive, it may be possible to recruit an equal number of Pakistani doctors to fill the vacancies created within the refugee program. As these doctors would be working on a fixed term contract, perhaps the regular refugee health staff would not object to the pay differentials. The doctors and paramedics who agree to a fixed term contract for work inside Afghanistan will also need financial support.

If the approach is considered feasible and a donor agency determines that additional costs are justified, the next step would be to reach an agreement with the health care providers within the refugee relief system and prepare an operational plan.

Alternative II

Bob Brenner, Freedom Medicine, suggested that the present trainees be given a one-month advanced first aid-type course and sent back to their respective commanders or a Mujahideen training camp to teach basic first aid to the Mujahideen for a one or two-month period. This plan has merit

in that it would not be disruptive for ongoing programs and, more importantly, it would be possible to train a fairly large number of Mujahideen on how to apply lifesaving first aid measures on the battlefield as well as measures for protecting an injury from unnecessary complications. For example, Freedom Medicine has 15 trainees. If each trainee taught First Aid to five Mujahideen in a week, the output in two months would be 600 trained Mujahideen (15 trainees x 5 Mujahideen x 8 weeks = 600 trained Mujahideen). As stated above, a well-designed operational plan would have to be prepared plus the allocation of funds to cover the additional costs.

A Health Planning Matrix

As previously mentioned, the general theme or emphasis of the training programs is to prepare medical technicians to provide medical support for the Mujahideen. This is their stated primary objective, and through hard work and dedicated effort considerable progress has been made toward that objective.

However, while discussing training content little attention was given for the problems of children and mothers. This is alarming, as even during normal periods these two groups experience the highest morbidity and mortality rates. Given the present situation in "resistance"-controlled areas inside Afghanistan, it can only be concluded that the health status of these two groups will have declined dramatically. An Afghan medical doctor stated a European nurse reported that in the area where she is working inside Afghanistan, 95% of the newborns die because of neonatal tetanus. Perhaps this is an exaggeration, but if it is only half true, the situation is still

alarming Information from another source was that during a bombing raid on a village most of the pregnant mothers aborted because of the trauma associated with the bombing and fleeing from the area

The future of the resistance movement as well as Afghanistan's identity depends not only on the survival of the children but for these children to grow up strong and healthy Newspaper and other reports suggest that this concept is well understood by the powers that wish to subjugate Afghanistan as evidenced by toy bombs, indiscriminate bombing of the civilian population, destruction of food crops, shelter, etc plus a systematic education program for children under their jurisdiction Therefore, not only from a humanitarian point of view, the very survival of Afghanistan and its ability to secure and maintain a free and independent status very strongly suggests that assistance be provided on an urgent basis for children and mothers as well as the mujahideen The child survival intervention techniques are relatively basic and not very complex Many of these techniques could be implemented (perhaps not to the extent desired) even in the present difficult situation in "resistance"-controlled areas. Party leaders and their associated health committees should have little difficulty understanding the child and mother survival concept.

There are still population groups which should be considered while developing a comprehensive medical assistance plan However, as more groups are considered, the more complex the task becomes In order to reduce the complexity of the task, it would be useful to first examine the relative health risk factors experienced by nine major population groups, i e Mujahideen (males 15-45 years), newborn, infants, 1-5 years, pregnant

and lactating mothers, 6-15 years, females 15-45 years, females 45 years plus, males 15-45 years, and males 45 years plus. This breakdown more or less follows the epidemiological approach for examining a health problem, which states that age is the single most important factor followed by sex and environmental factors. Each population group, although overlap occurs, experiences specific health problems that are age and sex specific. For each group, theoretically it should be possible to list out the health problems or conditions which usually produce the highest incidence of morbidity and mortality. The health risks could then be prioritized according to the magnitude or relative risk for each factor. A matrix could then be developed to include an objective priority, i.e. immediate, intermediate and long-term. The health risk factors for each population group could then be placed in one of the three objective categories.

To test the practicability of the matrix, health risk factors for each group were listed and placed in the matrix against the objective category, keeping in view operational feasibility. Therefore, although a health risk factor may fall within a high priority, operational considerations, i.e. what it takes to accomplish the objective, suggests that the health risk should be placed in the intermediate or even long-term category. There are gray areas regarding whether a health risk factor should be in one or the other categories and overlap exists, but generally the matrix provides at a glance an overall picture of the needs and priorities. Such a matrix should help planners decide whether to support a particular activity and be useful for guiding the medical assistance toward those problems which are most urgent and, if addressed, the capacity for

achieving or maximizing the impact of the assistance effort. A draft matrix is included in Appendix V. It should be kept in mind, however, that this is only a draft matrix and requires refinement.

To carry out a health risk factor analysis, specific data regarding the current medical care needs/problems inside Afghanistan is required. Probably this type of data is not available. It should be possible, though, to acquire a sufficient body of knowledge by interviewing medical and non-medical people who have had recent experience in Afghanistan as well as reviewing previously published health statistics on Afghanistan for such an analysis.

APPENDIX I
TERMS OF REFERENCE

Background

The Office of Afghan Affairs directs humanitarian assistance activities for war-affected Afghans in "resistance"-controlled areas of Afghanistan. Various groups, including private and voluntary organizations (PVOs), are assisting with this humanitarian effort. PVOs such as International Medical Corps and Freedom Medicine are directing their efforts to the provision of medical training and medical aid/supplies, others provide medical services inside Afghanistan, while several PVOs distribute cash-for-food and food itself.

Introduction

Approximately five PVOs, both American and European, are currently running and/or developing skill levels to work inside Afghanistan. Afghans are being trained as first aiders, nurses and surgeons. In some cases training is very basic and lasts a week, other programs are more technical and strenuous, lasting up to 18 months. The training takes place in the Northwest Frontier Province and the tribal areas along the Pakistani-Afghan border. Trainees receive both classroom and field exposure in order to develop their skills. Upon completion of their training, the Afghans return to Afghanistan, where they serve both civilians and Mujahideen wounded. In most cases, Mujahideen return to their commander inside Afghanistan. While most receive training in treatment of war injuries, many are capable of providing assistance in

public health as well. For those receiving more advanced training, treatment of infectious disease is also possible.

As the AID-assisted PVO medical training programs are in the early implementation phase, some of the PVOs have requested assistance to further develop their training plans. It also would be appropriate for a training specialist to examine the training programs in general. He should provide suggestions which may be useful for improving the training plans as well as for strengthening the capacity of the trainees to serve both the Mujahideen and civilian medical needs.

Scope of Work

A specialist is required for this activity who has experience with paramedical course curriculum development and paramedical training programs. In addition, working experience in Pakistan is desirable. The specialist will be expected to work with the PVOs and to coordinate his activities with the Office of the AID/REP in Peshawar. He will accomplish the following tasks:

- A provide a status report on the medical training programs (goals, objectives, operational plans, training methodologies) currently being conducted by five (5) USAID-assisted PVOs involved with training Afghans to provide medical assistance within "resistance"-controlled areas of Afghanistan,
- B where appropriate, assist the PVOs to further develop training plans,
- C identify training topics that might be included or given more emphasis to further strengthen the capabilities of the trainees to serve both Mujahideen and civilian medical needs,

- D present observations and impressions regarding the training programs in general and the existing status of coordination,
- E provide suggestions which may be helpful for further strengthening the overall medical assistance plan

Level of Effort

This individual should be available to begin work as soon as possible for a full six weeks. The contractor will be based in Peshawar, Pakistan, where he will work six-day work weeks. His point of contact among the PVOs will be Gaye Brenner, Freedom Medicine. She can be reached through the U S Consulate in Peshawar.

Reports

The contractor will prepare a final report covering above scope of work for submission to the AID/REP office prior to his departure. He should also submit two copies of documents, if any, provided to PVOs.

APPENDIX II

PRIVATE VOLUNTARY ORGANIZATIONS RECEIVING USAID SUPPORT

for

TRAINING AFGHAN PARAMEDICS

<u>Name of Organization</u>	<u>Country</u>
1 Freedom Medicine	America
2 German-Afghan Committee	Germany
3 International Medical Corps	America
4 Medical Training for Afghans	Belgium and France
5 Surgical Training for Afghan Doctors and Nurses	France

APPENDIX III
PRINCIPAL CONTACTS

<u>Organization</u>	<u>Name</u>
USAID	Al Nehoda
Freedom Medicine	Gaye Le Clere Brenner Robert Brenner Susanne Brown, M D Joel Warren James Wengenroth
German-Afghan Committee	Mr M E Rashid Rolf Lerch
International Medical Corps	Dr Roashan Leonard Leshuk Robert Simon, M D Jane Orlando
Medical Training for Afghans	Michel Tonneau Dr Henri Metzger
Surgical Training for Afghan Doctors and Nurses	Arielle Calmejane Jacques Omayon

APPENDIX IV

DEVELOPMENT OF A MODEL COURSE OUTLINE FOR FREEDOM MEDICINE

During the six-week period a request was made by Freedom Medicine to assist with the orientation of three new trainers and to work on development of course materials. A total of 12 days were spent on the activity (eight days at the Peshawar headquarters and four days at the training center).

Initially time was devoted to discussing various training approaches, appropriate skill/knowledge levels and training content/design for a six-month paramedical training course.

Based on these discussions and referencing the Army Corpsman course manuals and other manuals, content areas were identified and a model course outline prepared. This was followed by defining some of the important tasks and skills for each subject topic. As time was limited, this planning exercise could not be completed but was sufficiently advanced to provide a base for beginning the course.

From time to time progress reports were presented to the program managers to obtain their views and suggestions regarding the model outline. Specifically, the goal for this planning activity was to introduce the trainers to a methodology for systematically developing a course outline (hopefully relevant) including the defining of tasks, duties, skills and knowledge components. Therefore, it should not be assumed that the attached model course outline is the outline that will actually be implemented for this training program.

While at the training center, emergency first aid was introduced and the training focused on practical application of skills through simulated exercises. Following the initial first aid course, the trainees will be expected to train the Security Guard attached to the Center in first aid skills. This is an excellent approach for not only developing teaching skills but reinforcement of first aid skill/knowledge among the paramedical trainees. A series of simulated training exercises are planned to be carried out at appropriate times.

A Model Course Outline for Freedom Medicine's
Six-month Paramedical Training

<u>Module</u>	<u>Subject</u>
I	Emergency Medical/Surgical Treatment
II	Basic Clinical Skills and Techniques
III	Common Clinical Problems
IV	Special Problems of Women and Children
V	Community Health
VI	Field Operations

HEALTH PLANNING MATRIX

	1 MUNILDEEN MALES 15-45 YEARS OLD	2 NEWBORNS	3 INFANTS	4 1 TO 5 YEARS OLD	5 PREGNANT AND LACTATING WOMEN	6 6 TO 15 YEARS OLD	7 FEMALES 16 TO 45 YEARS OLD	8 FEMALES 46 PLUS YEARS OLD	9 MALES 46 PLUS YEARS OLD
IMMEDIATE 0 TO 9 MONTHS	WOUNDS AND TRAUMA INJURY RELATED CONFLICTATIONS ACUTE COMMON CLINICAL PROBLEMS	TETANUS CONJ. INFECTION EYE INFECTION	DIARRHEA/ DEHYDRATION HIGH FEVER PNEUMONIA	DIARRHEA/ DEHYDRATION MALNUTRITION PARASITES HIGH FEVER PNEUMONIA WOUNDS AND TRAUMA	ANEMIA POSTPARTUM HEMORRHAGE WOUNDS AND TRAUMA	WOUNDS AND TRAUMA	WOUNDS AND TRAUMA	WOUNDS AND TRAUMA	WOUNDS AND TRAUMA
INTERMEDIATE 10 TO 4 MONTHS			FEEDING PROBLEMS SUPPLEMENTAL FEEDS	INFECTIONS, i.e. EAR, EYE, SPIN RESPIRATORY IMMUNIZATION	OBSTETRICAL EMERGENCIES POSTPARTUM INFECTIONS	UNDER-NUTRITION ACUTE COMMON CLINICAL PROBLEMS	ACUTE COMMON CLINICAL PROBLEMS URINARY TRACT INFECTIONS	ACUTE COMMON CLINICAL PROBLEMS	ACUTE COMMON CLINICAL PROBLEMS
LONG TERM 50 MONTHS PLUS	INJURY-RELATED HANDICAPS CHRONIC COMMON CLINICAL PROBLEMS	LOW BIRTH WEIGHT CONGENITAL DEFECTS		COMMON CHILDHOOD COMMUNICABLE DISEASES MEANING PROBLEMS EMOTIONAL PROBLEMS	HIGH RISK PREGNANCY SIGNS/SYMPTOMS LACTATION PROBLEMS BREAST-INFECTIONS EMOTIONAL PROBLEMS	EMOTIONAL PROBLEMS	GYNECOLOGICAL PROBLEMS, INFECTIONS CHRONIC CLINICAL PROBLEMS EMOTIONAL PROBLEMS	CHRONIC COMMON CLINICAL PROBLEMS	CHRONIC COMMON CLINICAL PROBLEMS